

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11331

11316

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Salisbury</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fisher Nursing Home</i>				d. STREET ADDRESS <i>Amara St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Mary</i> Middle <i>Elizabeth</i> Last <i>Barnick</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>18</i> Year <i>1961</i>		5. SEX <i>F.</i>		6. COLOR OR RACE <i>W.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 5 1871</i>		9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>13</i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dom Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Barnick</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Graham</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Harold B. Plummer</i>		Address <i>Washington, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO <i>20 yrs.</i> (c) <i>arteriosclerotic heart disease</i> <i>20 years</i>								INTERVAL BETWEEN ONSET AND DEATH <i>10 days -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral deafness</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>4-24</i> 19 <i>61</i> to <i>10-18</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>10-17</i> 19 <i>61</i> , and that death occurred at <i>10-18</i> 19 <i>61</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Harold B. Plummer</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Harold B. Plummer</i>				22d. ADDRESS <i>Preston Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Oct. 21, 61</i>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City, town, or county) <i>Beltsville</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 23 61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

11011

UNITED STATES OF AMERICA

11011



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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11318

1. PLACE OF DEATH a. COUNTY Dorchester Co.	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Md.	b. COUNTY Dorchester Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crocheron, Md.	c. LENGTH OF STAY IN lb 42 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crocheron Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crocheron, Md;	d. STREET ADDRESS Crocheron, Md.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Bennett	4. DATE OF DEATH Oct. 16, 1961	5. SEX Female
6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1872
9. AGE (In years last birthday) 88 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Holland Island, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME George Waller	14. MOTHER'S MAIDEN NAME Sarah Waller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT Milton Bennett Crocheron, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH 30 Mins.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	DATE SIGNED 10/19/61	Address (Street, city, town, or county) Cambridge, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 18, 1961	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery
22d. LOCATION (City, town, or country) Cambridge Md.	24a. REC'D BY REGISTRAR OCT 24 1961	24b. REGISTRAR'S SIGNATURE Arthur S. Hume
23. FUNERAL DIRECTOR LeCompte Funeral Service	23. FUNERAL DIRECTOR Cambridge, Md.	23. FUNERAL DIRECTOR Cambridge, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11333

11318

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>		c. LENGTH OF STAY IN 1b <u>22</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hurlock - Shiloh Road</u>				d. STREET ADDRESS <u>Hurlock - Shiloh Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milbourne</u> Middle <u>Brewington</u> Last <u>Brinsfield</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 1, 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Brinsfield</u>				14. MOTHER'S MAIDEN NAME <u>Cleo Hurley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-28-8344</u>		17. INFORMANT Address <u>Mrs. Katie E. Brinsfield, Hurlock, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42011</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic Heart Disease</u> DUE TO <u> </u> (c) <u>Essential Hypertension</u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH. <u>10 min.</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u> </u> <u> </u> p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <u> </u> Not while <u> </u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 29, 1960</u> to <u>Oct. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1961</u> and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jason F. G. Yee M.D.</u>		22b. DATE SIGNED <u>10-23-61</u>		22c. PHYSICIAN'S NAME (Type) <u>JASON F. G. YEE M.D.</u>			
22d. ADDRESS <u>Hurlock, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Orlino L. Hines</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G297 10/16/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. **11319**

11334

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.			c. LENGTH OF STAY IN 1b 70 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS Cambridge R.F.D. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Omar Middle B. Last Brown				4. DATE OF DEATH Month Oct. Day 8, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1885 May 10, 1961	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Refinisher	
10b. KIND OF BUSINESS OR INDUSTRY Furniture Repair		11. BIRTHPLACE (State or foreign country) Kent Island Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jashua Brown				14. MOTHER'S MAIDEN NAME Ella Bridges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Kenneth Lyons 1345 U St. SE, Washington, Dc			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 2 DAYS 420.1 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3/2 , 19 59 to 10/8 , 19 61 , that I last saw the deceased alive on 10/8 , 19 61 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 CHURCH ST DATE SIGNED 10/10/61 ACTUAL SIGNATURE W. E. GUNBY JR M.D. PHYSICIAN'S NAME (Type) W. E. GUNBY JR CAMBRIDGE MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 11, 1961		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '61		24b. REGISTRAR'S SIGNATURE Wm. S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The attending physician and coroner must be filled in by the funeral director. After this certificate has been signed by the attending physician and coroner, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11335											
11320											
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 9yr. 11mo. 24da d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 515 High Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ann Elizabeth Coleman					4. DATE OF DEATH Month October Day 30 Year 1961						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-86-1886		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ivens ? John H. Ivens					14. MOTHER'S MAIDEN NAME Unknown Sarah Elliott						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no					16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS - Eastern Shore State Hospital Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolus DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Oct. 30, 1961 , that (I) (we) last saw the deceased alive on October 30, 1961 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.											
22a. SIGNATURE John F. Schneider M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-30-61				
22c. PHYSICIAN'S NAME (Type) Dr. John F. Schneider					22d. ADDRESS E.S.S. Hospital, Cambridge, Md. 10-30-61						
23a. BURIAL, CREMATION, REMOVAL (Specify) Nov. 1, 1961 Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.					25a. REC'D BY REGISTRAR DATE NOV 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines				

1953



CERTIFICATE OF DEATH

Reg. Dist. No.

11321

11336

1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hills Point, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. STREET ADDRESS Cambridge R.F.D. # 3			
3. NAME OF DECEASED (Type or print) First Beatrice Middle V. Last Condon				4. DATE OF DEATH Month Oct. Day 30 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1910	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Neck Dist. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Condon				14. MOTHER'S MAIDEN NAME Mamie Woolen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Robert Marshall		Address Cambridge R.F.D. # 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic nephritis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus, Mental retardation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 13 , 19 61 , to Oct 30 , 19 61 , that I last saw the deceased alive on Oct 30 , 19 61 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert E. Bunker				ADDRESS (Street, city or town, state) 200 Maryland Ave., Cambridge Md 21613			
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.				DATE SIGNED Nov 16, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1961		22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE NOV 7 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11538

M

<p>1. Name of deceased: WILLIAM J. BROWN</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1890-01-15</p>		<p>4. Place of birth: St. Louis, Mo.</p>	
<p>5. Date of death: 1940-01-15</p>		<p>6. Place of death: St. Louis, Mo.</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Immediate cause: Myocardial infarction</p>	
<p>9. Duration of illness: 2 weeks</p>		<p>10. Usual place of abode: St. Louis, Mo.</p>	
<p>11. Name of physician: Dr. J. H. Smith</p>		<p>12. Name of attending nurse: Miss Mary Jones</p>	
<p>13. Name of informant: Dr. J. H. Smith</p>		<p>14. Name of informant: Miss Mary Jones</p>	
<p>15. Name of informant: Dr. J. H. Smith</p>		<p>16. Name of informant: Miss Mary Jones</p>	
<p>17. Name of informant: Dr. J. H. Smith</p>		<p>18. Name of informant: Miss Mary Jones</p>	
<p>19. Name of informant: Dr. J. H. Smith</p>		<p>20. Name of informant: Miss Mary Jones</p>	
<p>21. Name of informant: Dr. J. H. Smith</p>		<p>22. Name of informant: Miss Mary Jones</p>	
<p>23. Name of informant: Dr. J. H. Smith</p>		<p>24. Name of informant: Miss Mary Jones</p>	
<p>25. Name of informant: Dr. J. H. Smith</p>		<p>26. Name of informant: Miss Mary Jones</p>	
<p>27. Name of informant: Dr. J. H. Smith</p>		<p>28. Name of informant: Miss Mary Jones</p>	
<p>29. Name of informant: Dr. J. H. Smith</p>		<p>30. Name of informant: Miss Mary Jones</p>	
<p>31. Name of informant: Dr. J. H. Smith</p>		<p>32. Name of informant: Miss Mary Jones</p>	
<p>33. Name of informant: Dr. J. H. Smith</p>		<p>34. Name of informant: Miss Mary Jones</p>	
<p>35. Name of informant: Dr. J. H. Smith</p>		<p>36. Name of informant: Miss Mary Jones</p>	
<p>37. Name of informant: Dr. J. H. Smith</p>		<p>38. Name of informant: Miss Mary Jones</p>	
<p>39. Name of informant: Dr. J. H. Smith</p>		<p>40. Name of informant: Miss Mary Jones</p>	
<p>41. Name of informant: Dr. J. H. Smith</p>		<p>42. Name of informant: Miss Mary Jones</p>	
<p>43. Name of informant: Dr. J. H. Smith</p>		<p>44. Name of informant: Miss Mary Jones</p>	
<p>45. Name of informant: Dr. J. H. Smith</p>		<p>46. Name of informant: Miss Mary Jones</p>	
<p>47. Name of informant: Dr. J. H. Smith</p>		<p>48. Name of informant: Miss Mary Jones</p>	
<p>49. Name of informant: Dr. J. H. Smith</p>		<p>50. Name of informant: Miss Mary Jones</p>	
<p>51. Name of informant: Dr. J. H. Smith</p>		<p>52. Name of informant: Miss Mary Jones</p>	
<p>53. Name of informant: Dr. J. H. Smith</p>		<p>54. Name of informant: Miss Mary Jones</p>	
<p>55. Name of informant: Dr. J. H. Smith</p>		<p>56. Name of informant: Miss Mary Jones</p>	
<p>57. Name of informant: Dr. J. H. Smith</p>		<p>58. Name of informant: Miss Mary Jones</p>	
<p>59. Name of informant: Dr. J. H. Smith</p>		<p>60. Name of informant: Miss Mary Jones</p>	
<p>61. Name of informant: Dr. J. H. Smith</p>		<p>62. Name of informant: Miss Mary Jones</p>	
<p>63. Name of informant: Dr. J. H. Smith</p>		<p>64. Name of informant: Miss Mary Jones</p>	
<p>65. Name of informant: Dr. J. H. Smith</p>		<p>66. Name of informant: Miss Mary Jones</p>	
<p>67. Name of informant: Dr. J. H. Smith</p>		<p>68. Name of informant: Miss Mary Jones</p>	
<p>69. Name of informant: Dr. J. H. Smith</p>		<p>70. Name of informant: Miss Mary Jones</p>	
<p>71. Name of informant: Dr. J. H. Smith</p>		<p>72. Name of informant: Miss Mary Jones</p>	
<p>73. Name of informant: Dr. J. H. Smith</p>		<p>74. Name of informant: Miss Mary Jones</p>	
<p>75. Name of informant: Dr. J. H. Smith</p>		<p>76. Name of informant: Miss Mary Jones</p>	
<p>77. Name of informant: Dr. J. H. Smith</p>		<p>78. Name of informant: Miss Mary Jones</p>	
<p>79. Name of informant: Dr. J. H. Smith</p>		<p>80. Name of informant: Miss Mary Jones</p>	
<p>81. Name of informant: Dr. J. H. Smith</p>		<p>82. Name of informant: Miss Mary Jones</p>	
<p>83. Name of informant: Dr. J. H. Smith</p>		<p>84. Name of informant: Miss Mary Jones</p>	
<p>85. Name of informant: Dr. J. H. Smith</p>		<p>86. Name of informant: Miss Mary Jones</p>	
<p>87. Name of informant: Dr. J. H. Smith</p>		<p>88. Name of informant: Miss Mary Jones</p>	
<p>89. Name of informant: Dr. J. H. Smith</p>		<p>90. Name of informant: Miss Mary Jones</p>	
<p>91. Name of informant: Dr. J. H. Smith</p>		<p>92. Name of informant: Miss Mary Jones</p>	
<p>93. Name of informant: Dr. J. H. Smith</p>		<p>94. Name of informant: Miss Mary Jones</p>	
<p>95. Name of informant: Dr. J. H. Smith</p>		<p>96. Name of informant: Miss Mary Jones</p>	
<p>97. Name of informant: Dr. J. H. Smith</p>		<p>98. Name of informant: Miss Mary Jones</p>	
<p>99. Name of informant: Dr. J. H. Smith</p>		<p>100. Name of informant: Miss Mary Jones</p>	

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11337

11322

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON	
c. LENGTH OF STAY IN 1b 3 1/4 YRS.		d. STREET ADDRESS Rural 07X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE CORRIDEAN		4. DATE OF DEATH Oct. 30 1961	
5. SEX ♀	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-71
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME REED, Thomas M.		14. MOTHER'S MAIDEN NAME HARRIS, Rachel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS IRENE MERREY		Address ELKTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) LEFT SIDED HEART FAILURE DUE TO (c) ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 3 YEARS 7 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DEHYDRATION & INANITION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-19 1958 to 10-30 1961 , that (I) (was) last saw the deceased alive on 10-30 1961 , and that death occurred at 4 AM , from the causes and on the date stated above.			
22a. SIGNATURE Geo M. Dunn		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) GEO. M. DUNN, M.D.		22d. ADDRESS EAST. SHORE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/61	
23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City, town, or county) (State) Elkton MD	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md.		25a. REC'D BY REGISTRAR DATE NOV 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur J. Harris			

MEDICAL CERTIFICATION

(M)

11337

11337

11337

THE STATE OF TEXAS,
COUNTY OF DALLAS,
I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, State of Texas.

WITNESSED my hand and the seal of said County at Dallas, Texas, this _____ day of _____, 19____.

CLERK OF COUNTY

Item 18 Fill 298 10-30-60 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>					c. LENGTH OF STAY IN 1b <u>19 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>E.S.S. Hospital</u>					d. STREET ADDRESS <u>05 X-2</u>					
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>—</u> Last <u>Dulin</u>					4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1961</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1880</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>E.S.S. Hospital Records</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized arteriosclerosis with C.V.D.</u> DUE TO <u>sever. yrs.</u> (c) <u>with cardiovascular disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Octob. 3, 1961, to Octob. 22, 1961</u>, that (I) (we) last saw the deceased alive on <u>Octob. 21, 1961</u>, and that death occurred at <u>8:11 M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Simon Virkutis</u>					22b. DATE SIGNED <u>10/22/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>SIMON VIRKUTIS</u>					22d. ADDRESS <u>E.S.S. Hospital, Cambridge, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>10/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		23d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>					ADDRESS <u>Church Hill Ind.</u>		25a. REC'D BY REGISTRAR <u>DATE 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Kline</u>	

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11338

CERTIFICATE OF DEATH

11323

MEDICAL CERTIFICATION

RECEIVED

1133



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the DUTY MEDICAL EXAMINER should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11339 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11324	
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Dor.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock				c. LENGTH OF STAY IN TB All life		X CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock R.F.D. (Bobtown)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D.						e. STREET ADDRESS 1				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence			First Elbert			Last Elbert			4. DATE OF DEATH Month October Day 18 Year 19 61		
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/26/03		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Day labor		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edgar Elbert						14. MOTHER'S MAIDEN NAME Bertha Atkinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Edgar Elbert, Hurlock, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 10/18/61		
EXAMINER'S NAME (Type) John Mace Jr.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Oct. 21, 1961		22c. NAME OF CEMETERY OR CREMATORY Thompsontown Cemetery		22d. LOCATION (City, town, or country) (State) Near East New Market, Maryland	
23. FUNERAL DIRECTOR ADDRESS J.J. Framptom and Son, Federalsburg, Maryland						24a. REC'D BY REGISTRAR OCT 24 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11340
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RFD 2) MD.		c. LENGTH OF STAY IN 1b 3 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS SOUTH SOMERSET AVE.	
3. NAME OF DECEASED (Type or print) First JOHN Middle TYLER Last EVANS		4. DATE OF DEATH Month OCT Day 10 Year 1961	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-80
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SOLOMON EVANS		14. MOTHER'S MAIDEN NAME ANNA E. BRADSHAW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-03-1445	
17. INFORMANT Address EASTERN SHORE STATE HOSPITAL RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL DEGENERATION DUE TO (c) ATHEROSCLEROTIC C.V.D.		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HR. 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from JULY 7, 1961 to OCT. 10, 1961 , that (he) (we) last saw the deceased alive on OCT. 10, 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Geo M. Dunn		22b. DATE SIGNED 10-10-61	
22c. PHYSICIAN'S NAME (Type) George M. DUNN, M.D.		22d. ADDRESS Eastern Shore State Hospital, Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 12, 1961	
23c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE CEMETERY		23d. LOCATION (City, town, or county) (State) CRISFIELD, MARYLAND Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Bradshaw		ADDRESS CRISFIELD, MD.	
25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Carlton L. Farris	

FOR STATE
HEALTH DEPT.

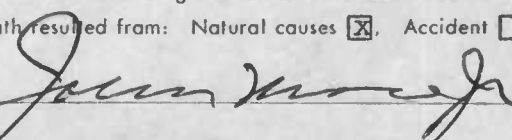
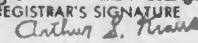
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11326

11341

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital			d. STREET ADDRESS 59 Douglass St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Maggie Hayward Fields			4. DATE OF DEATH October 16 19 61		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1898		9. AGE (in years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Beckwith, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Samuel W. Hayward		
14. MOTHER'S MAIDEN NAME Cornelia Henson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-07-7947			17. INFORMANT Edmond Haywadr 59 Douglass Cambridge		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Colitis 577.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Massive hemorrhage (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/31/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/61		22c. NAME OF CEMETERY OR CREMATORY Bethel	
22d. LOCATION (City, town, or county) (State) Cambridge Maryland		24a. REC'D BY REGISTRAR DATE NOV 6 '61			
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St.Clair		ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please
 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 2. Give Pages 1, 2, and 3 to the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Film #299- 11/1/61- MB.

Two for one certificate - First reported on
Reg. death cert. signed by Dr. J. Edwin Foxitt,
Cambridge, Md.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11327

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Aireys Cambridge Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--- Aireys			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Johnann Fisher				4. DATE OF DEATH Month October Day 17 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29, 1889	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dorchester County	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John W. Stanley				14. MOTHER'S MAIDEN NAME Millie Kiah			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Raymond Fisher				Address Rt. #2 Dorchester Co.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Abt. 4 da.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/23/61 DATE SIGNED Address (Street, city, town, or county)							
ACTUAL SIGNATURE John Mace Jr.		EXAMINER'S NAME (Type) John Mace Jr. M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/61		22c. NAME OF CEMETERY OR CREMATORY Aireys		22d. LOCATION (City, town, or country) (State) Aireys, Maryland	
23. FUNERAL DIRECTOR Herbert M. St. Clair				24a. REC'D BY REGISTRAR OCT 26 '61			
ADDRESS Cambridge, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be executed at any time within 72 hours after death. Pages 1, 2, and 3 to be executed by the funeral director. Page 4 to be executed by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

John Smith

RECEIVED
JAN 10 1900
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11343

CERTIFICATE OF DEATH

Reg. Dist. No. 11328

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek			
c. LENGTH OF STAY IN life				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emmons Middle N. Last Foster				4. DATE OF DEATH Month October Day 9 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 12, 1900	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min. 61		IF UNDER 24 HRS. Months 61 Days 61 Hours 61 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alfred Foster				14. MOTHER'S MAIDEN NAME Sarah Kiah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-03-9769		17. INFORMANT Hazel Foster-Church Creek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pemphigus 704.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 704.1 DUE TO (c) 704.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 704.1				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 1961 , to October 9, 1961 , that I last saw the deceased alive on October 9, 1961 , and that death occurred at 10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 227 Pine St., Cambridge, Md. DATE SIGNED 10/10/61							
ACTUAL SIGNATURE J. Edwin Fassett, M.D.				PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/13/61		22c. NAME OF CEMETERY OR CREMATORY Rock Cemetery		22d. LOCATION (City, town, or county) (State) Christ Rock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Clair				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE OCT 26 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11329

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge, Md		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS 72 CHESTNUT WAY			
3. NAME OF DECEASED (Type or print) Theodosia Benton Greene				4. DATE OF DEATH October 11 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1981	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ashley Benton				14. MOTHER'S MAIDEN NAME Sallie CROWDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Medical Records, Eastern Shore State Hosp., Cambridge			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 78 2.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Fe mur						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell getting out of bed.					
20c. TIME OF INJURY Month, Day, Year 5:10 a.m. 11-24-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) E.S.S. Hosp.		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED				22b. DATE THEREOF 10-12-61		22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR Oct 13 61	
						24b. REGISTRAR'S SIGNATURE Arthur S. H...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11328

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF TEXAS
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11345

11330

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b 38 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 106 PEACHBLOSSOM AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALVINA Middle PETERS Last HINTZ				4. DATE OF DEATH Month OCTOBER Day 2 Year 1961			
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8, 1874	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) APPLETON, WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT PETERS				14. MOTHER'S MAIDEN NAME FREDRIKA PETERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GLADYS HINTZ			Address CAMBRIDGE, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atypical Pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/29/61 , 19... to 10/12/61 , 19... that (I) (we) last saw the deceased alive on 10/14/61 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John Mace Jr. M.D.				22b. DATE SIGNED 10/13/61		22c. ADDRESS CAMBRIDGE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-4-61		23c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET		23d. LOCATION (City, town or county) (State) EAST NEW MARKET MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas				25a. REC'D BY REGISTRAR DATE OCT 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

347

[illegible]

1895

1

128141

Q10 320180AA

20. 3. 1951

CERTIFICATE OF DEATH

11331

Reg. Dist. No.

11346

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY N.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md, Glenburn Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smyrna Delaware	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		d. STREET ADDRESS 46 X-2	
3. NAME OF DECEASED (Type or print) First Lonah H. Middle Hodgson Last 		4. DATE OF DEATH 10/21/61 Month 10 Day 21 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1873
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Henry M. Smith		14. MOTHER'S MAIDEN NAME Mary Wiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT M.S. Hodgson		Address Bunker Hill Farm, Trappe Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branches pneumonia 42008 DUE TO Arterio sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis (c) 			INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1, 1961 , to 10-21 , 19 61 , that I last saw the deceased alive on 10-21 , 19 61 , and that death occurred at 11 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Winters		ADDRESS (Street, city or town, state) DATE SIGNED 2107 Bore Easton Md 10/21/61	
PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/61	22c. NAME OF CEMETERY OR CREMATORY Townsend Cemetery	22d. LOCATION (City, town, or county) (State) Townsend Delaware
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Daniel Middleton		ADDRESS Baltimore Md.	
24a. REC'D BY REGISTRAR DATE OCT 26 '61		24b. REGISTRAR'S SIGNATURE Arthur P. H. H.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11268

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11347											
11332											
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 313 Race St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elizabeth M. Jones						4. DATE OF DEATH Month October Day 3 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1906		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public School Teacher						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nerbert McMahon						14. MOTHER'S MAIDEN NAME Mannah Saunders					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO. 213-24-0421		17. INFORMANT Kenneth R. Jones Address Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary sclerosis DUE TO (c) ?											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-30-61 to 10-3-61 , that (I) (we) last saw the deceased alive on 10-3-61 , and that death occurred at 10:30 a.m. from the causes and on the date stated above.											
22a. SIGNATURE Eldridge H. Wolff M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-4-61			
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.						22d. ADDRESS 15 Locust St., Cambridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 6, 1961		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town or county) (State) Boston, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas Jr.						25a. REC'D BY REGISTRAR OCT 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

11388

11388

M

Director

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

11348

CERTIFICATE OF DEATH

Reg. Dist. No.

11333

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wingate, Md.</u>			
c. LENGTH OF STAY IN 1b <u>18 Days</u>				d. STREET ADDRESS <u>Wingate, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Winnie</u> Middle <u>H.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1888</u>		9. AGE (In years last birthday) yrs. <u>73</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (State or foreign country) <u>Wingate, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob T. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eldred Jones</u> Address <u>Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of prostate with metastasis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Oct. 9, 61</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 9, 1961</u> , to <u>Oct. 27, 1961</u> that I last saw the deceased alive on <u>Oct. 27, 1961</u> and that death occurred at <u>4 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St., Cambridge, Maryland</u> DATE SIGNED <u>Nov. 4, 61</u>							
ACTUAL SIGNATURE <u>W. H. Henke</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. W. H. Henke, M.D.</u> <u>Cambridge, Maryland</u> <u>Nov. 4, 61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 29, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wingate, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> ADDRESS <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11334

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if deceased lived, if deceased lived) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 15 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 1 Broad		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James W. Kelly		First James		Middle W.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10b. KIND OF BUSINESS OR INDUSTRY Canning plant		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William J. Kelly		14. MOTHER'S MAIDEN NAME Georgia Howeth		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Orem Kelly		17. INFORMANT Seaford, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tension pneumothorax, left. 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Crushing wound of chest. DUE TO (c) 15 Hrs.		INTERVAL BETWEEN ONSET AND DEATH 15 Hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of a car which failed to make curve, struck a tree.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 4		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Driver of a car which failed to make curve, struck a tree.			
20c. TIME OF INJURY Month, Day, Year 10/13/61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 14	
20f. (City or town) Rhodesdale, Dor., Md.		20g. (County) Rhodesdale, Dor., Md.		20h. (State) Rhodesdale, Dor., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/16/61	
ACTUAL SIGNATURE John Mace Jr.		M.D. John Mace Jr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/61		22c. NAME OF CEMETERY OR CREMATORY McKendree Cemetery	
22d. LOCATION (City, town, or country) Rhodesdale, Dor., Md.		22e. (State) Rhodesdale, Dor., Md.			
23. FUNERAL DIRECTOR Willoughby Funeral Home East New Market, Md.		24a. RECEIVED BY REGISTRAR OCT 19 1961		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11350

11335

Item 9 Film Q300

11/9/61 JWK

1
FOR STATE
HEALTH DEPT

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the County Health Officer or the County Health Officer's designee. The County Health Officer or the County Health Officer's designee should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the County Health Officer. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY in lb

8 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

20 Cross St.

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Dorchester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

d. STREET ADDRESS

20 Cross St.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

Roosevelt

Middle

Last

McCloud

4. DATE OF DEATH

Month

October

Day

8

Year

1961

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Unknown

9. AGE (In years last birthday)

40 years

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Florida or Georgia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service)

Unknown

16. SOCIAL SECURITY NO.

252-40-0162

17. INFORMANT

City Police Dept.

Address

Cambridge

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Acute alcoholism

INTERVAL BETWEEN ONSET AND DEATH

?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John Mace Jr. M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

11/2/61

Address (Street, city, town, or county)

Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/23/61

22c. NAME OF CEMETERY OR CREMATORY

Waugh

22d. LOCATION (City, town, or county)

Cambridge

Maryland

23. FUNERAL DIRECTOR

ADDRESS

Herbert M. St.Clair Cambridge, Md.

24a. REC'D BY REGISTRAR

NOV 6 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

1138

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1

James [unclear]

12/1/61

James E. [unclear] [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11351

11336

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 8½ years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS 405 Choptank Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Ann Medford				4. DATE OF DEATH Month October Day 2 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1883		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Loudon County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph B. Woodward				14. MOTHER'S MAIDEN NAME Sarah Ann Woodward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Herbert S. Slacum, Cambridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Broncho pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Massive cerebral hemorrhage with left hemiplegia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 hr. 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-16-61 to 10-2-1961, that (I) (we) last saw the deceased alive on 10-2-61 19, and that death occurred at 11:55 PM from the causes and on the date stated above.							
22a. SIGNATURE Eldridge H. Wolff			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-4-61		
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			22d. ADDRESS 15 Locust St., Cambridge, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 5, 1961		23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City, town, or county) (State) Hurlock, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR OCT 10 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

1008

UNITED STATES DEPARTMENT OF AGRICULTURE

12321



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11352

Reg. Dist. No. 11357

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
c. LENGTH OF STAY IN 1b 1 yr & 10 mos		d. STREET ADDRESS 1939-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest First Middle Last		4. DATE OF DEATH October 17, 19 61 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/75
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mister		14. MOTHER'S MAIDEN NAME Mary Pruitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 218-40-5081	
17. INFORMANT Hospita 1 Records E.S.S.H. Cambridge, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of femur, right 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) slipped and fell on the ground	
20c. TIME OF INJURY Month, Day, Year 10:45 a.m. June 26 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Cambridge Dorchester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace, Jr.		DATE SIGNED October 17, 1961	
EXAMINER'S NAME (Type) John Mace, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 19, 1961	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Marion Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons H.N. Bradshaw		24a. REC'D BY REGISTRAR DATE OCT 23 '61	
ADDRESS Crisfield		24b. REGISTRAR'S SIGNATURE ...	

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Date of Death: _____

7. Time of Death: _____

8. Place of Death: _____

9. Cause of Death: _____

10. Manner of Death: _____

11. Signature of Medical Examiner: _____

12. Signature of Coroner: _____

13. Signature of Registrar: _____

14. Signature of Physician: _____

15. Signature of Nurse: _____

16. Signature of Undertaker: _____

17. Signature of Burial Society: _____

18. Signature of Cemetery: _____

19. Signature of Funeral Home: _____

20. Signature of Other: _____

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11353

CERTIFICATE OF DEATH

Reg. Dist. No.

11338

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roland Middle Westly Last Neal				4. DATE OF DEATH Month October Day 29 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 34, 1899	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isiah Neal		14. MOTHER'S MAIDEN NAME Millie E. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Rev. Edward Hughes		Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 26, 1961 , to Oct 29, 1961 that I last saw the deceased alive on October 29, 1961 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Cambridge, Md. DATE SIGNED 10-29-61							
ACTUAL SIGNATURE J. Edwin Fassett, M.D.				M.D. 227 Pine St., Cambridge, Md.			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/61		22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or county) (State) East New Market, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				24a. REC'D BY REGISTRAR DATE NOV 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

I

CERTIFICATE OF DEATH

11323

M

1. PLACE OF DEATH At home		2. NAME OF DECEASED John Doe	
3. SEX Male		4. AGE 45	
5. RACE White		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. DATE OF BIRTH 1910	
9. DATE OF DEATH 1950		10. TIME OF DEATH 10:00 AM	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF BIRTH Maryland	
13. SIGNATURE OF DECEASED John Doe		14. SIGNATURE OF WITNESS John Doe	
15. SIGNATURE OF PHYSICIAN John Doe		16. SIGNATURE OF CLERK John Doe	
17. SIGNATURE OF JUDGE John Doe		18. SIGNATURE OF NOTARY John Doe	
19. SIGNATURE OF CORONER John Doe		20. SIGNATURE OF SHERIFF John Doe	
21. SIGNATURE OF DISTRICT ATTORNEY John Doe		22. SIGNATURE OF COUNTY CLERK John Doe	
23. SIGNATURE OF CITY CLERK John Doe		24. SIGNATURE OF STATE CLERK John Doe	
25. SIGNATURE OF FEDERAL CLERK John Doe		26. SIGNATURE OF POSTAL CLERK John Doe	
27. SIGNATURE OF TELEPHONE CLERK John Doe		28. SIGNATURE OF RAILROAD CLERK John Doe	
29. SIGNATURE OF AIRLINE CLERK John Doe		30. SIGNATURE OF MARINE CLERK John Doe	
31. SIGNATURE OF NAVY CLERK John Doe		32. SIGNATURE OF ARMY CLERK John Doe	
33. SIGNATURE OF AIR FORCE CLERK John Doe		34. SIGNATURE OF SPACE CLERK John Doe	
35. SIGNATURE OF OTHER CLERK John Doe		36. SIGNATURE OF OTHER CLERK John Doe	
37. SIGNATURE OF OTHER CLERK John Doe		38. SIGNATURE OF OTHER CLERK John Doe	
39. SIGNATURE OF OTHER CLERK John Doe		40. SIGNATURE OF OTHER CLERK John Doe	
41. SIGNATURE OF OTHER CLERK John Doe		42. SIGNATURE OF OTHER CLERK John Doe	
43. SIGNATURE OF OTHER CLERK John Doe		44. SIGNATURE OF OTHER CLERK John Doe	
45. SIGNATURE OF OTHER CLERK John Doe		46. SIGNATURE OF OTHER CLERK John Doe	
47. SIGNATURE OF OTHER CLERK John Doe		48. SIGNATURE OF OTHER CLERK John Doe	
49. SIGNATURE OF OTHER CLERK John Doe		50. SIGNATURE OF OTHER CLERK John Doe	
51. SIGNATURE OF OTHER CLERK John Doe		52. SIGNATURE OF OTHER CLERK John Doe	
53. SIGNATURE OF OTHER CLERK John Doe		54. SIGNATURE OF OTHER CLERK John Doe	
55. SIGNATURE OF OTHER CLERK John Doe		56. SIGNATURE OF OTHER CLERK John Doe	
57. SIGNATURE OF OTHER CLERK John Doe		58. SIGNATURE OF OTHER CLERK John Doe	
59. SIGNATURE OF OTHER CLERK John Doe		60. SIGNATURE OF OTHER CLERK John Doe	
61. SIGNATURE OF OTHER CLERK John Doe		62. SIGNATURE OF OTHER CLERK John Doe	
63. SIGNATURE OF OTHER CLERK John Doe		64. SIGNATURE OF OTHER CLERK John Doe	
65. SIGNATURE OF OTHER CLERK John Doe		66. SIGNATURE OF OTHER CLERK John Doe	
67. SIGNATURE OF OTHER CLERK John Doe		68. SIGNATURE OF OTHER CLERK John Doe	
69. SIGNATURE OF OTHER CLERK John Doe		70. SIGNATURE OF OTHER CLERK John Doe	
71. SIGNATURE OF OTHER CLERK John Doe		72. SIGNATURE OF OTHER CLERK John Doe	
73. SIGNATURE OF OTHER CLERK John Doe		74. SIGNATURE OF OTHER CLERK John Doe	
75. SIGNATURE OF OTHER CLERK John Doe		76. SIGNATURE OF OTHER CLERK John Doe	
77. SIGNATURE OF OTHER CLERK John Doe		78. SIGNATURE OF OTHER CLERK John Doe	
79. SIGNATURE OF OTHER CLERK John Doe		80. SIGNATURE OF OTHER CLERK John Doe	
81. SIGNATURE OF OTHER CLERK John Doe		82. SIGNATURE OF OTHER CLERK John Doe	
83. SIGNATURE OF OTHER CLERK John Doe		84. SIGNATURE OF OTHER CLERK John Doe	
85. SIGNATURE OF OTHER CLERK John Doe		86. SIGNATURE OF OTHER CLERK John Doe	
87. SIGNATURE OF OTHER CLERK John Doe		88. SIGNATURE OF OTHER CLERK John Doe	
89. SIGNATURE OF OTHER CLERK John Doe		90. SIGNATURE OF OTHER CLERK John Doe	
91. SIGNATURE OF OTHER CLERK John Doe		92. SIGNATURE OF OTHER CLERK John Doe	
93. SIGNATURE OF OTHER CLERK John Doe		94. SIGNATURE OF OTHER CLERK John Doe	
95. SIGNATURE OF OTHER CLERK John Doe		96. SIGNATURE OF OTHER CLERK John Doe	
97. SIGNATURE OF OTHER CLERK John Doe		98. SIGNATURE OF OTHER CLERK John Doe	
99. SIGNATURE OF OTHER CLERK John Doe		100. SIGNATURE OF OTHER CLERK John Doe	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11354

11339

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i> c. LENGTH OF STAY IN <i>Jewell's X Suplock</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Cambridge Maryland Charles</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <i>MD</i> b. COUNTY <i>Dor</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Blanche Mc-Bride Phillips</i>			4. DATE OF DEATH Month <i>10</i> Day <i>17</i> Year <i>1961</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <i>9/17/1897</i>		9. AGE (In years last birthday) <i>64</i> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland U.S.A.</i>					
13. FATHER'S NAME <i>Thomas E. Mc-Bride</i>			14. MOTHER'S MAIDEN NAME <i>Charles Brewster</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>15-123456789</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO (b) <i>Left Pneumonia</i> DUE TO (c) <i>493X</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Nutritional Anemia Severe</i>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <i>10/17/61</i> to <i>10/17/61</i> , that (I) (we) last saw the deceased alive on <i>10/17/61</i> , and that death occurred <i>10/17/61</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>W. H. H. HARKS</i>				22b. DATE SIGNED <i>10/18/61</i>					
22c. PHYSICIAN'S NAME (Type) <i>W. H. H. HARKS</i>				22d. ADDRESS <i>CAC BRIDGE MARYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/19/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dor. Memorial</i>					
23d. LOCATION (City, town or county) <i>Cambridge</i>		(State) <i>MD</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 24 '61</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Harkness</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harkness</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11861

11861

1

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11355

CERTIFICATE OF DEATH

Reg. Dist. No.

11340

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Aireys, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--- Aireys, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Ella Middle Pinder Last		4. DATE OF DEATH Month October Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1864
9. AGE (In years lost birthday) yrs. 97		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Dorchester, County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wilson		14. MOTHER'S MAIDEN NAME Elizabeth Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Agnes Thomas		Address Aireys, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Heart Disease 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Decompensation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 16, 1960 to October 16, 1961 , that I last saw the deceased alive on October 16, 1961 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. 227 Pine St., Cambridge, Md. 10-16-61 PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/61	
22c. NAME OF CEMETERY OR CREMATORY Fork Neck		22d. LOCATION (City, town, or county) (State) Fork Neck, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Clair, Jr.		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR ACT 26 '61		24b. REGISTRAR'S SIGNATURE [Signature]	

2251Y

CERTIFICATE OF DEATH

Reg. Dist. No.

11341

11356

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md..				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, Maryland.			
f. STREET ADDRESS East New Market, Maryland.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First J. Middle Ernest Last Redmile		4. DATE OF DEATH		Month Oct. Day 31. Year 19 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1908	9. AGE (In years lost birthday) 53 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Cosmetics		11. BIRTHPLACE (State or foreign country) Lancaster, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Not Known		17. INFORMANT Mrs. Redmile Address East New Market, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/27 , 19 61 , to 10/31 , 19 61 , that I last saw the deceased alive on 10/31 , 19 61 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 LOCUST ST. CAMBRIDGE MARYLAND DATE SIGNED 10/31/61							
ACTUAL SIGNATURE W. H. Hanks, M.D.				PHYSICIAN'S NAME (Type) W. H. HANKS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1961		22c. NAME OF CEMETERY OR CREMATORY Northwood Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE NOV 7 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11328

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PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 10 1900	
STREET		AGE	
CITY		SEX	
COUNTY		RACE	
STATE		OCCUPATION	
COUNTRY		EDUCATION	
RELIGION		MARRIAGE	
SPOUSE		CHILDREN	
PARENTS		SIBLINGS	
GRANDPARENTS		OTHER RELATIVES	
FRIENDS		NEIGHBORS	
CLERGY		MEDICAL ATTENDANCE	
HOSPITAL		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		PROGNOSIS	
MORALITY		HYGIENE	
NUTRITION		EXERCISE	
REST		STRESS	
EMOTIONS		SOCIAL LIFE	
HISTORY		PRESENT CASE	
PREVIOUS CASES		FAMILY HISTORY	
PERSONAL HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
X-RAY		AUTOPSY	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
BACTERIOLOGICAL FINDINGS		VIROLOGICAL FINDINGS	
IMMUNOLOGICAL FINDINGS		TOXICOLOGICAL FINDINGS	
OTHER FINDINGS		CONCLUSIONS	
REMARKS		SIGNATURE	
DATE		PLACE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11357

11342

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>		c. LENGTH OF STAY in 1b <u>1 YR</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RISEING SUN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EASTERN SHORE STATE HOSP.</u>			d. STREET ADDRESS <u>NONE</u>		
3. NAME OF DECEASED (Type or print) First <u>VIOLET</u> Middle <u>LUCY</u> Last <u>RIALE</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>31</u> Year <u>1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/06</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CECIL COUNTY, MD.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-14-0871</u>		17. INFORMANT <u>THOMAS RIALE, RISEING SUN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>1 YR +</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ABSCESS RT. BUTTOCK</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 27, 1960</u> , to <u>OCT. 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT. 30, 1961</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>George H. Longley</u>		22b. DATE SIGNED <u>10/31/61</u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>	
22d. ADDRESS <u>EASTERN SHORE STATE HOSPITAL</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BROOKVIEW CEMETERY</u>	
23d. LOCATION (City, town or county) <u>RISEING SUN</u>		23e. (State) <u>CECIL</u>		23f. (County) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed</u>		24a. ADDRESS <u>Rising Sun, Md.</u>		24b. DATE <u>NOV 1 '61</u>	
24c. REGISTRAR'S SIGNATURE <u>—</u>		24d. REGISTRAR'S SIGNATURE <u>—</u>		24e. REGISTRAR'S SIGNATURE <u>—</u>	

11322

CENTRE OF GRAVITY

11322

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in the "Remarks" section. The certificate should be executed by the Deputy Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11343

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 15 Mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) E.S.S. Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Caroline c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greensboro DENTON d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clara A. Ribbardson		4. DATE OF DEATH 10-21 1961		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1871, July 27		9. AGE (in years last birthday) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown PETER HIGNUTT	
14. MOTHER'S MAIDEN NAME Unknown MARTHA NEAL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Records E.S.S. Hospital, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 782.4 DUE TO (b) Fracture Neck femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Fall out of bed.		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall out of bed.	
20c. TIME OF INJURY 4.20 PM Month, Day, Year 10-14-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20f. (City or town) Cambridge (County) Dor. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 10-21-61		EXAMINER'S NAME (Type) John Mace Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1961		22c. NAME OF CEMETERY OR CREMATORY Denton	
22d. LOCATION (City, town, or country) Denton, Md.		22e. REC'D BY REGISTRAR OCT 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
23. FUNERAL DIRECTOR J. Virgil Moore		ADDRESS Denton		24a. REC'D BY REGISTRAR OCT 25 '61	

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Records 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840,

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11359		11344	
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge c. LENGTH OF STAY IN 1b 1 yr. 8 mo. 28 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill d. STREET ADDRESS 17X-2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Edward Robinson First Middle Last 4. DATE OF DEATH Oct 1 1961 Month Day Year		5. SEX M 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1/15-02 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Robinson 14. MOTHER'S MAIDEN NAME Meg Bromley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital records Cambridge Md Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 286.5 Uremia due to mal-nutrition DUE TO (a) 286.5 DUE TO (b) mal-nutrition DUE TO (c) Unk PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 4 1960 to OCT 1 1961 , that (I) (we) last saw the deceased alive on OCT 1 1961 and that death occurred at 8:30 PM , from the causes and on the date stated above. 22a. SIGNATURE Thomas J. Dredge M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D. 22d. ADDRESS E.S.S. Hospital, Cambridge, Md. 22b. DATE SIGNED 10-1-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF Oct. 4 23c. NAME OF CEMETERY, OR CREMATORY Chesterfield 23d. LOCATION (City, town, or county) (State) Centreville Ind.		24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill Md. 25a. REC'D BY REGISTRAR DATE OCT 5 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

11328

(M)

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CERTIFICATE OF DEATH

Reg. Dist. No.

11345

11360

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.			c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				d. STREET ADDRESS Hoopersville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Fred C. Ruark				4. DATE OF DEATH Month Day Year Oct. 4, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1874		9. AGE (In years, last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ruark				14. MOTHER'S MAIDEN NAME Elizabeth Meekins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Elizabeth Simmons Hoopersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) SENILITY							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/30, 1961 , to 10/4, 1961 , that I last saw the deceased alive on 10/4, 1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 104 Locust St Cambridge Md 10/6/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '61		24b. REGISTRAR'S SIGNATURE Charles E. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES M. JONES		M		35		W		Teacher		Baltimore, Md.		Jan 15, 1918		10:30 AM		Heart Disease		Natural		J. M. Jones		J. M. Jones	
13. PLACE OF DEATH		14. NAME OF PHYSICIAN		15. NAME OF HOSPITAL		16. NAME OF NURSE		17. NAME OF BURIAL PLACE		18. NAME OF MINISTER		19. NAME OF WITNESSES		20. NAME OF CORONER		21. NAME OF JURY		22. NAME OF JUDGE		23. NAME OF CLERK		24. NAME OF SHERIFF	
Home		J. M. Jones		None		None		None		None		None		None		None		None		None		None	
25. NAME OF CITY		26. NAME OF COUNTY		27. NAME OF STATE		28. NAME OF COUNTRY		29. NAME OF DISTRICT		30. NAME OF WARD		31. NAME OF BLOCK		32. NAME OF LOT		33. NAME OF GRAVE		34. NAME OF MONUMENT		35. NAME OF PLANT		36. NAME OF FLOWER	
Baltimore		Baltimore		Maryland		United States		None		None		None		None		None		None		None		None	
37. NAME OF STREET		38. NAME OF AVENUE		39. NAME OF BOULEVARD		40. NAME OF PARK		41. NAME OF SQUARE		42. NAME OF PLAZA		43. NAME OF GARDEN		44. NAME OF TERRACE		45. NAME OF DRIVE		46. NAME OF LANE		47. NAME OF ALLEY		48. NAME OF COURT	
None		None		None		None		None		None		None		None		None		None		None		None	
49. NAME OF BRIDGE		50. NAME OF TUNNEL		51. NAME OF CANAL		52. NAME OF RIVER		53. NAME OF LAKE		54. NAME OF BAY		55. NAME OF SOUND		56. NAME OF STRAIT		57. NAME OF GULF		58. NAME OF OCEAN		59. NAME OF SEA		60. NAME OF MOUNTAIN	
None		None		None		None		None		None		None		None		None		None		None		None	
61. NAME OF HILL		62. NAME OF VALLEY		63. NAME OF PLAIN		64. NAME OF DESERT		65. NAME OF SANDHILL		66. NAME OF SWAMP		67. NAME OF MARSH		68. NAME OF PRAIRIE		69. NAME OF MEADOW		70. NAME OF FARM		71. NAME OF RANCH		72. NAME OF ESTATE	
None		None		None		None		None		None		None		None		None		None		None		None	
73. NAME OF VILLAGE		74. NAME OF TOWN		75. NAME OF CITY		76. NAME OF COUNTY		77. NAME OF STATE		78. NAME OF COUNTRY		79. NAME OF DISTRICT		80. NAME OF WARD		81. NAME OF BLOCK		82. NAME OF LOT		83. NAME OF GRAVE		84. NAME OF MONUMENT	
None		None		None		None		None		None		None		None		None		None		None		None	
85. NAME OF PLANT		86. NAME OF FLOWER		87. NAME OF FRUIT		88. NAME OF LEAF		89. NAME OF BARK		90. NAME OF ROOT		91. NAME OF SEED		92. NAME OF STEM		93. NAME OF TWIG		94. NAME OF BRANCH		95. NAME OF CANE		96. NAME OF SPORE	
None		None		None		None		None		None		None		None		None		None		None		None	
97. NAME OF MUSHROOM		98. NAME OF FUNGUS		99. NAME OF BACTERIA		100. NAME OF VIRUS		101. NAME OF PARASITE		102. NAME OF INSECT		103. NAME OF MAMMAL		104. NAME OF BIRD		105. NAME OF REPTILE		106. NAME OF AMPHIBIAN		107. NAME OF MOLLUSK		108. NAME OF CRUSTACEAN	
None		None		None		None		None		None		None		None		None		None		None		None	
109. NAME OF FISH		110. NAME OF AMPHIBIAN		111. NAME OF REPTILE		112. NAME OF BIRD		113. NAME OF MAMMAL		114. NAME OF INSECT		115. NAME OF MOLLUSK		116. NAME OF CRUSTACEAN		117. NAME OF FISH		118. NAME OF AMPHIBIAN		119. NAME OF REPTILE		120. NAME OF BIRD	
None		None		None		None		None		None		None		None		None		None		None		None	
121. NAME OF MAMMAL		122. NAME OF BIRD		123. NAME OF REPTILE		124. NAME OF AMPHIBIAN		125. NAME OF MOLLUSK		126. NAME OF CRUSTACEAN		127. NAME OF FISH		128. NAME OF AMPHIBIAN		129. NAME OF REPTILE		130. NAME OF BIRD		131. NAME OF MAMMAL		132. NAME OF INSECT	
None		None		None		None		None		None		None		None		None		None		None		None	
133. NAME OF MOLLUSK		134. NAME OF CRUSTACEAN		135. NAME OF FISH		136. NAME OF AMPHIBIAN		137. NAME OF REPTILE		138. NAME OF BIRD		139. NAME OF MAMMAL		140. NAME OF INSECT		141. NAME OF MOLLUSK		142. NAME OF CRUSTACEAN		143. NAME OF FISH		144. NAME OF AMPHIBIAN	
None		None		None		None		None		None		None		None		None		None		None		None	
145. NAME OF REPTILE		146. NAME OF BIRD		147. NAME OF MAMMAL		148. NAME OF INSECT		149. NAME OF MOLLUSK		150. NAME OF CRUSTACEAN		151. NAME OF FISH		152. NAME OF AMPHIBIAN		153. NAME OF REPTILE		154. NAME OF BIRD		155. NAME OF MAMMAL		156. NAME OF INSECT	
None		None		None		None		None		None		None		None		None		None		None		None	
157. NAME OF MAMMAL		158. NAME OF BIRD		159. NAME OF REPTILE		160. NAME OF AMPHIBIAN		161. NAME OF MOLLUSK		162. NAME OF CRUSTACEAN		163. NAME OF FISH		164. NAME OF AMPHIBIAN		165. NAME OF REPTILE		166. NAME OF BIRD		167. NAME OF MAMMAL		168. NAME OF INSECT	
None		None		None		None		None		None		None		None		None		None		None		None	
169. NAME OF INSECT		170. NAME OF MOLLUSK		171. NAME OF CRUSTACEAN		172. NAME OF FISH		173. NAME OF AMPHIBIAN		174. NAME OF REPTILE		175. NAME OF BIRD		176. NAME OF MAMMAL		177. NAME OF INSECT		178. NAME OF MOLLUSK		179. NAME OF CRUSTACEAN		180. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
181. NAME OF AMPHIBIAN		182. NAME OF REPTILE		183. NAME OF BIRD		184. NAME OF MAMMAL		185. NAME OF INSECT		186. NAME OF MOLLUSK		187. NAME OF CRUSTACEAN		188. NAME OF FISH		189. NAME OF AMPHIBIAN		190. NAME OF REPTILE		191. NAME OF BIRD		192. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
193. NAME OF INSECT		194. NAME OF MOLLUSK		195. NAME OF CRUSTACEAN		196. NAME OF FISH		197. NAME OF AMPHIBIAN		198. NAME OF REPTILE		199. NAME OF BIRD		200. NAME OF MAMMAL		201. NAME OF INSECT		202. NAME OF MOLLUSK		203. NAME OF CRUSTACEAN		204. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
205. NAME OF AMPHIBIAN		206. NAME OF REPTILE		207. NAME OF BIRD		208. NAME OF MAMMAL		209. NAME OF INSECT		210. NAME OF MOLLUSK		211. NAME OF CRUSTACEAN		212. NAME OF FISH		213. NAME OF AMPHIBIAN		214. NAME OF REPTILE		215. NAME OF BIRD		216. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
217. NAME OF INSECT		218. NAME OF MOLLUSK		219. NAME OF CRUSTACEAN		220. NAME OF FISH		221. NAME OF AMPHIBIAN		222. NAME OF REPTILE		223. NAME OF BIRD		224. NAME OF MAMMAL		225. NAME OF INSECT		226. NAME OF MOLLUSK		227. NAME OF CRUSTACEAN		228. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
229. NAME OF AMPHIBIAN		230. NAME OF REPTILE		231. NAME OF BIRD		232. NAME OF MAMMAL		233. NAME OF INSECT		234. NAME OF MOLLUSK		235. NAME OF CRUSTACEAN		236. NAME OF FISH		237. NAME OF AMPHIBIAN		238. NAME OF REPTILE		239. NAME OF BIRD		240. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
241. NAME OF INSECT		242. NAME OF MOLLUSK		243. NAME OF CRUSTACEAN		244. NAME OF FISH		245. NAME OF AMPHIBIAN		246. NAME OF REPTILE		247. NAME OF BIRD		248. NAME OF MAMMAL		249. NAME OF INSECT		250. NAME OF MOLLUSK		251. NAME OF CRUSTACEAN		252. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
253. NAME OF AMPHIBIAN		254. NAME OF REPTILE		255. NAME OF BIRD		256. NAME OF MAMMAL		257. NAME OF INSECT		258. NAME OF MOLLUSK		259. NAME OF CRUSTACEAN		260. NAME OF FISH		261. NAME OF AMPHIBIAN		262. NAME OF REPTILE		263. NAME OF BIRD		264. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
265. NAME OF INSECT		266. NAME OF MOLLUSK		267. NAME OF CRUSTACEAN		268. NAME OF FISH		269. NAME OF AMPHIBIAN		270. NAME OF REPTILE		271. NAME OF BIRD		272. NAME OF MAMMAL		273. NAME OF INSECT		274. NAME OF MOLLUSK		275. NAME OF CRUSTACEAN		276. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
277. NAME OF AMPHIBIAN		278. NAME OF REPTILE		279. NAME OF BIRD		280. NAME OF MAMMAL		281. NAME OF INSECT		282. NAME OF MOLLUSK		283. NAME OF CRUSTACEAN		284. NAME OF FISH		285. NAME OF AMPHIBIAN		286. NAME OF REPTILE		287. NAME OF BIRD		288. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
289. NAME OF INSECT		290. NAME OF MOLLUSK		291. NAME OF CRUSTACEAN		292. NAME OF FISH		293. NAME OF AMPHIBIAN		294. NAME OF REPTILE		295. NAME OF BIRD		296. NAME OF MAMMAL		297. NAME OF INSECT		298. NAME OF MOLLUSK		299. NAME OF CRUSTACEAN		300. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
301. NAME OF AMPHIBIAN		302. NAME OF REPTILE		303. NAME OF BIRD		304. NAME OF MAMMAL		305. NAME OF INSECT		306. NAME OF MOLLUSK		307. NAME OF CRUSTACEAN		308. NAME OF FISH		309. NAME OF AMPHIBIAN		310. NAME OF REPTILE		311. NAME OF BIRD		312. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
313. NAME OF INSECT		314. NAME OF MOLLUSK		315. NAME OF CRUSTACEAN		316. NAME OF FISH		317. NAME OF AMPHIBIAN		318. NAME OF REPTILE		319. NAME OF BIRD		320. NAME OF MAMMAL		321. NAME OF INSECT		322. NAME OF MOLLUSK		323. NAME OF CRUSTACEAN		324. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
325. NAME OF AMPHIBIAN		326. NAME OF REPTILE		327. NAME OF BIRD		328. NAME OF MAMMAL		329. NAME OF INSECT		330. NAME OF MOLLUSK		331. NAME OF CRUSTACEAN		332. NAME OF FISH		333. NAME OF AMPHIBIAN		334. NAME OF REPTILE		335. NAME OF BIRD		336. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
337. NAME OF INSECT		338. NAME OF MOLLUSK		339. NAME OF CRUSTACEAN		340. NAME OF FISH		341. NAME OF AMPHIBIAN		342. NAME OF REPTILE		343. NAME OF BIRD		344. NAME OF MAMMAL		345. NAME OF INSECT		346. NAME OF MOLLUSK		347. NAME OF CRUSTACEAN		348. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
349. NAME OF AMPHIBIAN		350. NAME OF REPTILE		351. NAME OF BIRD		352. NAME OF MAMMAL		353. NAME OF INSECT		354. NAME OF MOLLUSK		355. NAME OF CRUSTACEAN		356. NAME OF FISH		357. NAME OF AMPHIBIAN		358. NAME OF REPTILE		359. NAME OF BIRD		360. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
361. NAME OF INSECT		362. NAME OF MOLLUSK		363. NAME OF CRUSTACEAN		364. NAME OF FISH		365. NAME OF AMPHIBIAN		366. NAME OF REPTILE		367. NAME OF BIRD		368. NAME OF MAMMAL		369. NAME OF INSECT		370. NAME OF MOLLUSK		371. NAME OF CRUSTACEAN		372. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
373. NAME OF AMPHIBIAN		374. NAME OF REPTILE		375. NAME OF BIRD		376. NAME OF MAMMAL		377. NAME OF INSECT		378. NAME OF MOLLUSK		379. NAME OF CRUSTACEAN		380. NAME OF FISH		381. NAME OF AMPHIBIAN		382. NAME OF REPTILE		383. NAME OF BIRD		384. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
385. NAME OF INSECT		386. NAME OF MOLLUSK		387. NAME OF CRUSTACEAN		388. NAME OF FISH		389. NAME OF AMPHIBIAN		390. NAME OF REPTILE		391. NAME OF BIRD		392. NAME OF MAMMAL		393. NAME OF INSECT		394. NAME OF MOLLUSK		395. NAME OF CRUSTACEAN		396. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
397. NAME OF AMPHIBIAN		398. NAME OF REPTILE		399. NAME OF BIRD		400. NAME OF MAMMAL		401. NAME OF INSECT		402. NAME OF MOLLUSK		403. NAME OF CRUSTACEAN		404. NAME OF FISH		405. NAME OF AMPHIBIAN		406. NAME OF REPTILE		407. NAME OF BIRD		408. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
409. NAME OF INSECT		410. NAME OF MOLLUSK		411. NAME OF CRUSTACEAN		412. NAME OF FISH		413. NAME OF AMPHIBIAN		414. NAME OF REPTILE		415. NAME OF BIRD		416. NAME OF MAMMAL		417. NAME OF INSECT		418. NAME OF MOLLUSK		419. NAME OF CRUSTACEAN		420. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
421. NAME OF AMPHIBIAN		422. NAME OF REPTILE		423. NAME OF BIRD		424. NAME OF MAMMAL		425. NAME OF INSECT		426. NAME OF MOLLUSK		427. NAME OF CRUSTACEAN		428. NAME OF FISH		429. NAME OF AMPHIBIAN		430. NAME OF REPTILE		431. NAME OF BIRD		432. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
433. NAME OF INSECT		434. NAME OF MOLLUSK		435. NAME OF CRUSTACEAN		436. NAME OF FISH		437. NAME OF AMPHIBIAN		438. NAME OF REPTILE		439. NAME OF BIRD		440. NAME OF MAMMAL		441. NAME OF INSECT		442. NAME OF MOLLUSK		443. NAME OF CRUSTACEAN		444. NAME OF FISH	
None		None		None		None		None		None		None		None		None		None		None		None	
445. NAME OF AMPHIBIAN		446. NAME OF REPTILE		447. NAME OF BIRD		448. NAME OF MAMMAL		449. NAME OF INSECT		450. NAME OF MOLLUSK		451. NAME OF CRUSTACEAN		452. NAME OF FISH		453. NAME OF AMPHIBIAN		454. NAME OF REPTILE		455. NAME OF BIRD		456. NAME OF MAMMAL	
None		None		None		None		None		None		None		None		None		None		None		None	
457. NAME OF INSECT		458. NAME OF MOLLUSK		459. NAME OF CRUSTACEAN		460. NAME OF FISH		461. NAME OF AMPHIBIAN		462. NAME OF REPTILE		463. NAME OF BIRD		464. NAME OF MAMMAL		465. NAME OF INSECT		466. NAME OF MOLLUSK		467. NAME OF CRUSTACEAN		468. NAME OF FISH	
None		None																					

CERTIFICATE OF DEATH

Reg. Dist. No. **11346**

11361

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.			
c. LENGTH OF STAY IN 1b 50 Yrs.				d. STREET ADDRESS 211 West End Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbur Middle N. Last Slacum				4. DATE OF DEATH Month Oct. Day 20 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1893		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Taylors Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Slacum				14. MOTHER'S MAIDEN NAME Margaret Hurley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wilbur Slacum		Address 211 West End Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 8 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 20, 1961 to Oct 20, 1961 , that I last saw the deceased alive on Oct 20, 1961 , and that death occurred at 8:55 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert E. Bunker M.D.				ADDRESS (Street, city or town, state) 200 Maryland Ave, Cambridge, Md.			
DATE SIGNED 10/27/61							
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.				CAMBRIDGE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1961		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Maryland		24a. REC'D BY REGISTRAR DATE NOV 1 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RELAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 11362
 CERTIFICATE OF DEATH

11347

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2yrs-5mon.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital					
3. NAME OF DECEASED (Type or print) Charles M. Snitcher		4. DATE OF DEATH Month Oct. Day 21 Year 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/77	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.					
13. FATHER'S NAME Charles Snitcher		14. MOTHER'S MAIDEN NAME Smith Margaret Snitcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records, E.S.S.H., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/19/59 to 10/21 , that (I) (we) last saw the deceased alive on 10/20 , 19 61 , and that death occurred at 8:25 A.M. from the causes and on the date stated above.					
22a. SIGNATURE John F. Schneider		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type) John F. Schneider, M.D.		22d. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 23, 1961		23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery	
23d. LOCATION (City, town, or county) Crumpton, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Fellows		ADDRESS Millington, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume					

SHELX

11363

CERTIFICATE OF DEATH

Reg. Dist. No.

11348

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Wiley Last Stoker				4. DATE OF DEATH Month Oct. Day 14 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1889		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Wiley				14. MOTHER'S MAIDEN NAME Emma S. Reid			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Betty Williamson Address Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Hypertension C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity, simple						INTERVAL BETWEEN ONSET AND DEATH 10 days ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 19 61 , to Oct 14 19 61 , that I last saw the deceased alive on Oct 14 19 61 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 10/19/61							
ACTUAL SIGNATURE James G. Thompson M.D.		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 17, 1961		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service ADDRESS Cambridge Md.				24a. REC'D BY REGISTRAR DATE OCT 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11363

<p>1. Name of deceased: <i>Charles H. Thompson</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>Nov 10 1918</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart</i></p>	
<p>7. Signature of physician: <i>Wm. H. Thompson</i></p>		<p>8. Signature of registrar: <i>Wm. H. Thompson</i></p>	
<p>9. Name of informant: <i>Wm. H. Thompson</i></p>		<p>10. Address of informant: <i>123 Main St.</i></p>	
<p>11. Name of informant: <i>Wm. H. Thompson</i></p>		<p>12. Address of informant: <i>123 Main St.</i></p>	
<p>13. Name of informant: <i>Wm. H. Thompson</i></p>		<p>14. Address of informant: <i>123 Main St.</i></p>	
<p>15. Name of informant: <i>Wm. H. Thompson</i></p>		<p>16. Address of informant: <i>123 Main St.</i></p>	
<p>17. Name of informant: <i>Wm. H. Thompson</i></p>		<p>18. Address of informant: <i>123 Main St.</i></p>	
<p>19. Name of informant: <i>Wm. H. Thompson</i></p>		<p>20. Address of informant: <i>123 Main St.</i></p>	
<p>21. Name of informant: <i>Wm. H. Thompson</i></p>		<p>22. Address of informant: <i>123 Main St.</i></p>	
<p>23. Name of informant: <i>Wm. H. Thompson</i></p>		<p>24. Address of informant: <i>123 Main St.</i></p>	
<p>25. Name of informant: <i>Wm. H. Thompson</i></p>		<p>26. Address of informant: <i>123 Main St.</i></p>	
<p>27. Name of informant: <i>Wm. H. Thompson</i></p>		<p>28. Address of informant: <i>123 Main St.</i></p>	
<p>29. Name of informant: <i>Wm. H. Thompson</i></p>		<p>30. Address of informant: <i>123 Main St.</i></p>	
<p>31. Name of informant: <i>Wm. H. Thompson</i></p>		<p>32. Address of informant: <i>123 Main St.</i></p>	
<p>33. Name of informant: <i>Wm. H. Thompson</i></p>		<p>34. Address of informant: <i>123 Main St.</i></p>	
<p>35. Name of informant: <i>Wm. H. Thompson</i></p>		<p>36. Address of informant: <i>123 Main St.</i></p>	
<p>37. Name of informant: <i>Wm. H. Thompson</i></p>		<p>38. Address of informant: <i>123 Main St.</i></p>	
<p>39. Name of informant: <i>Wm. H. Thompson</i></p>		<p>40. Address of informant: <i>123 Main St.</i></p>	
<p>41. Name of informant: <i>Wm. H. Thompson</i></p>		<p>42. Address of informant: <i>123 Main St.</i></p>	
<p>43. Name of informant: <i>Wm. H. Thompson</i></p>		<p>44. Address of informant: <i>123 Main St.</i></p>	
<p>45. Name of informant: <i>Wm. H. Thompson</i></p>		<p>46. Address of informant: <i>123 Main St.</i></p>	
<p>47. Name of informant: <i>Wm. H. Thompson</i></p>		<p>48. Address of informant: <i>123 Main St.</i></p>	
<p>49. Name of informant: <i>Wm. H. Thompson</i></p>		<p>50. Address of informant: <i>123 Main St.</i></p>	
<p>51. Name of informant: <i>Wm. H. Thompson</i></p>		<p>52. Address of informant: <i>123 Main St.</i></p>	
<p>53. Name of informant: <i>Wm. H. Thompson</i></p>		<p>54. Address of informant: <i>123 Main St.</i></p>	
<p>55. Name of informant: <i>Wm. H. Thompson</i></p>		<p>56. Address of informant: <i>123 Main St.</i></p>	
<p>57. Name of informant: <i>Wm. H. Thompson</i></p>		<p>58. Address of informant: <i>123 Main St.</i></p>	
<p>59. Name of informant: <i>Wm. H. Thompson</i></p>		<p>60. Address of informant: <i>123 Main St.</i></p>	
<p>61. Name of informant: <i>Wm. H. Thompson</i></p>		<p>62. Address of informant: <i>123 Main St.</i></p>	
<p>63. Name of informant: <i>Wm. H. Thompson</i></p>		<p>64. Address of informant: <i>123 Main St.</i></p>	
<p>65. Name of informant: <i>Wm. H. Thompson</i></p>		<p>66. Address of informant: <i>123 Main St.</i></p>	
<p>67. Name of informant: <i>Wm. H. Thompson</i></p>		<p>68. Address of informant: <i>123 Main St.</i></p>	
<p>69. Name of informant: <i>Wm. H. Thompson</i></p>		<p>70. Address of informant: <i>123 Main St.</i></p>	
<p>71. Name of informant: <i>Wm. H. Thompson</i></p>		<p>72. Address of informant: <i>123 Main St.</i></p>	
<p>73. Name of informant: <i>Wm. H. Thompson</i></p>		<p>74. Address of informant: <i>123 Main St.</i></p>	
<p>75. Name of informant: <i>Wm. H. Thompson</i></p>		<p>76. Address of informant: <i>123 Main St.</i></p>	
<p>77. Name of informant: <i>Wm. H. Thompson</i></p>		<p>78. Address of informant: <i>123 Main St.</i></p>	
<p>79. Name of informant: <i>Wm. H. Thompson</i></p>		<p>80. Address of informant: <i>123 Main St.</i></p>	
<p>81. Name of informant: <i>Wm. H. Thompson</i></p>		<p>82. Address of informant: <i>123 Main St.</i></p>	
<p>83. Name of informant: <i>Wm. H. Thompson</i></p>		<p>84. Address of informant: <i>123 Main St.</i></p>	
<p>85. Name of informant: <i>Wm. H. Thompson</i></p>		<p>86. Address of informant: <i>123 Main St.</i></p>	
<p>87. Name of informant: <i>Wm. H. Thompson</i></p>		<p>88. Address of informant: <i>123 Main St.</i></p>	
<p>89. Name of informant: <i>Wm. H. Thompson</i></p>		<p>90. Address of informant: <i>123 Main St.</i></p>	
<p>91. Name of informant: <i>Wm. H. Thompson</i></p>		<p>92. Address of informant: <i>123 Main St.</i></p>	
<p>93. Name of informant: <i>Wm. H. Thompson</i></p>		<p>94. Address of informant: <i>123 Main St.</i></p>	
<p>95. Name of informant: <i>Wm. H. Thompson</i></p>		<p>96. Address of informant: <i>123 Main St.</i></p>	
<p>97. Name of informant: <i>Wm. H. Thompson</i></p>		<p>98. Address of informant: <i>123 Main St.</i></p>	
<p>99. Name of informant: <i>Wm. H. Thompson</i></p>		<p>100. Address of informant: <i>123 Main St.</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
To be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11364
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (near) Cambridge, Md.		c. LENGTH OF STAY IN 1b 15 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Richardson Avenue 1939-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dora Middle - Last Tawes		4. DATE OF DEATH Month October Day 28 Year 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-88
9. AGE (In years and birthday) 73 yrs.		IF UNDER 1 YEAR Months 1 Days 15	IF UNDER 24 HRS. Hours 1 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) not known Maryland
12. CITIZEN OF WHAT COUNTRY? not known USA		13. FATHER'S NAME not known Jesse D. Evans	
14. MOTHER'S MAIDEN NAME not known Rachel Ward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) not known No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Medical Records-Eastern Shore State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO 153-8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the colon with metastases DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 7-19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____		20g. (County) _____	
20h. (State) _____		21. I certify that (this hospital) attended the deceased from October 13, 1961 to October 28, 1961 , that (I) (M) last saw the deceased alive on Oct. 28, 1961 , and that death occurred at 5:48 A.M. from the causes and on the date stated above.	
22a. SIGNATURE John F. Schneider M.D.		22b. DATE October 28, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. John F. Schneider M.D.		22d. ADDRESS "Peachblossom" Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 30, 1961	23c. NAME OF CEMETERY OR CREMATORY SHANNON/PRINCE Crisfield Cem.
23d. LOCATION (City, town, or county) Crisfield Md		23e. (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey Bradshaw		25a. REC'D BY REGISTRAR NOV 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. DATE NOV 2 '61	

STATE OF OHIO
COUNTY OF CATH

11364

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[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document. The text is too light to transcribe accurately.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(M)
11365
11350
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 24 + 9 Mos				d. STREET ADDRESS Quantico Road - Rt 5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Claude Hamilton Taylor				4. DATE OF DEATH Month Day Year OCT 15 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 9, 1899	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY OWN Farm		11. BIRTHPLACE (State or foreign country) USA MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sidney Taylor				14. MOTHER'S MAIDEN NAME Elizabeth Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNK		17. INFORMANT Address Hospital Records Cambridge Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNK							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 3 1959 to OCT 15 1961 , that (I) we last saw the deceased alive on OCT 14 1961 , and that death occurred at 3:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Thomas J. Dredge M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-15-61	
22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-61		23c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Funeral Home Sam C. Hill				25a. REC'D BY REGISTRAR DATE OCT 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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11362

CENTRAL OFFICE

11361

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Sincerely" and "Yours" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11351**

11366

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 12 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. STREET ADDRESS 1 Bailey Rd.	
3. NAME OF DECEASED (Type or print) William Kirby Towers		4. DATE OF DEATH Oct. 14, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1887
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Towers		14. MOTHER'S MAIDEN NAME Sarah Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Towers		Address Bailey Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY EMBOLUS DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) gave rise to the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION			INTERVAL BETWEEN ONSET AND DEATH IMMED.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Alfred R. Maryanov M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/16/61	
EXAMINER'S NAME (Type) ALFRED R MARYANOV DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Oct. 16, 1961		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Easton, Maryland		24a. REC'D BY REGISTRAR DATE OCT 24 '61	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kane	

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NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
LOCALITY		CITY		COUNTY		STATE		ZIP	
OCCUPATION		EDUCATION		MARRIAGE		CHILDREN		SIBLINGS	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
PHYSICIAN		HOSPITAL		LABORATORY		X-RAY		AUTOPSY	
SIGNATURE		DATE		TIME		PLACE		WITNESSES	
NOTARY		JURY		CORONER		PROSECUTOR		DEFENSE	
FAMILY		FRIENDS		CLERGY		SCHOOL		COMMUNITY	
CITY		COUNTY		STATE		ZIP		COUNTRY	
DECEASED'S SIGNATURE		DECEASED'S DATE		DECEASED'S TIME		DECEASED'S PLACE		DECEASED'S WITNESSES	
DECEASED'S LOCALITY		DECEASED'S CITY		DECEASED'S COUNTY		DECEASED'S STATE		DECEASED'S ZIP	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION		DECEASED'S MARRIAGE		DECEASED'S CHILDREN		DECEASED'S SIBLINGS	
DECEASED'S PREVIOUS ILLNESS		DECEASED'S TREATMENT		DECEASED'S HISTORY		DECEASED'S FAMILY HISTORY		DECEASED'S SOCIAL HISTORY	
DECEASED'S PHYSICIAN		DECEASED'S HOSPITAL		DECEASED'S LABORATORY		DECEASED'S X-RAY		DECEASED'S AUTOPSY	
DECEASED'S SIGNATURE		DECEASED'S DATE		DECEASED'S TIME		DECEASED'S PLACE		DECEASED'S WITNESSES	
DECEASED'S NOTARY		DECEASED'S JURY		DECEASED'S CORONER		DECEASED'S PROSECUTOR		DECEASED'S DEFENSE	
DECEASED'S FAMILY		DECEASED'S FRIENDS		DECEASED'S CLERGY		DECEASED'S SCHOOL		DECEASED'S COMMUNITY	
DECEASED'S CITY		DECEASED'S COUNTY		DECEASED'S STATE		DECEASED'S ZIP		DECEASED'S COUNTRY	
DECEASED'S DECEASED'S SIGNATURE		DECEASED'S DECEASED'S DATE		DECEASED'S DECEASED'S TIME		DECEASED'S DECEASED'S PLACE		DECEASED'S DECEASED'S WITNESSES	
DECEASED'S DECEASED'S LOCALITY		DECEASED'S DECEASED'S CITY		DECEASED'S DECEASED'S COUNTY		DECEASED'S DECEASED'S STATE		DECEASED'S DECEASED'S ZIP	
DECEASED'S DECEASED'S OCCUPATION		DECEASED'S DECEASED'S EDUCATION		DECEASED'S DECEASED'S MARRIAGE		DECEASED'S DECEASED'S CHILDREN		DECEASED'S DECEASED'S SIBLINGS	
DECEASED'S DECEASED'S PREVIOUS ILLNESS		DECEASED'S DECEASED'S TREATMENT		DECEASED'S DECEASED'S HISTORY		DECEASED'S DECEASED'S FAMILY HISTORY		DECEASED'S DECEASED'S SOCIAL HISTORY	
DECEASED'S DECEASED'S PHYSICIAN		DECEASED'S DECEASED'S HOSPITAL		DECEASED'S DECEASED'S LABORATORY		DECEASED'S DECEASED'S X-RAY		DECEASED'S DECEASED'S AUTOPSY	
DECEASED'S DECEASED'S SIGNATURE		DECEASED'S DECEASED'S DATE		DECEASED'S DECEASED'S TIME		DECEASED'S DECEASED'S PLACE		DECEASED'S DECEASED'S WITNESSES	
DECEASED'S DECEASED'S NOTARY		DECEASED'S DECEASED'S JURY		DECEASED'S DECEASED'S CORONER		DECEASED'S DECEASED'S PROSECUTOR		DECEASED'S DECEASED'S DEFENSE	
DECEASED'S DECEASED'S FAMILY		DECEASED'S DECEASED'S FRIENDS		DECEASED'S DECEASED'S CLERGY		DECEASED'S DECEASED'S SCHOOL		DECEASED'S DECEASED'S COMMUNITY	
DECEASED'S DECEASED'S CITY		DECEASED'S DECEASED'S COUNTY		DECEASED'S DECEASED'S STATE		DECEASED'S DECEASED'S ZIP		DECEASED'S DECEASED'S COUNTRY	

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 11367
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 11352

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 mo. 23das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle - Last Walls		4. DATE OF DEATH Month October Day 20 Year 1961	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-77
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. E. Walls		14. MOTHER'S MAIDEN NAME Etta Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Laura Walls Ridgely, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis with Cardio-vascular Disease DUE TO (b) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Sev. yrs.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 28 1961 to October 20 1961 , that (I) (we) last saw the deceased alive on October 20 1961 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Simon Virkutis M.D.		22b. DATE SIGNED 10-20-61	
22c. PHYSICIAN'S NAME (Type) Dr. Simon Virkutis		22d. ADDRESS E.S.S. Hospital, Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-22-61	
23c. NAME OF CEMETERY OR CREMATORY Ridgely		23d. LOCATION (City, town, or county) (State) Ridgely, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Bouleis Jr. Greensboro, Md.		25a. RECEIVED BY REGISTRAR Oct 23 1961 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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11382

STATE OF TEXAS

11382

IN SENATE,
January 11, 1902.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1901.
BY
J. M. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS BOOK CONCERN, 1902.

CERTIFICATE OF DEATH

Reg. Dist. No.

11353

11368

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 day - 21hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Rt #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				d. STREET ADDRESS Cambridge R.F.D. # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beverly Middle Jean Last Willey				4. DATE OF DEATH Month October Day 30 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1961		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months 1 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eldridge Mace Willey				14. MOTHER'S MAIDEN NAME Verna Ernestine Wheatly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Verna Willey - Cambridge, Maryland Route #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital skull anomaly 758.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 Day 21 Hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/28 , 19 61 , to 10/30 , 19 61 , that I last saw the deceased alive on 10/30 , 19 61 , and that death occurred at 7:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks				ADDRESS (Street, city or town, state) 104 LOUIST ST CAMBRIDGE MARYLAND			
PHYSICIAN'S NAME (Type) W. H. Hanks				DATE SIGNED 10/30/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1961		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE NOV 3 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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